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MEDICAL SOCIETY OF SOUTHEAST MICHIGAN

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Testimony of Cheryl Gibson Fountain, MD, FACOG
September 9, 2009 – House Judiciary Committee
Re: Women's Health and Pregnancy Prevention Package

Good morning, my name is Cheryl Gibson Fountain; I am an Obstetrician Gynecologist with a practice in Wayne County for the past 20 years. I am a member of the Michigan State Medical Society (MSMS) Board of Directors, the Michigan Organization on Adolescent Sexual Health (MOASH) Board of Directors, the Michigan Council for Maternal and Child Health (MCMCH) Board of Directors, the Michigan Section of the American College of Obstetricians Gynecologists (MSACOG) Advisory Council and President-Elect of the Wayne County Medical Society.
On behalf of the MSMS, MOASH, MCMCH and MSACOG, I would like to thank the Chair and the members of the committee for the opportunity to testify in favor of the Women's Health and Pregnancy Prevention Package. My remarks will focus on Contraceptive Equity for which I have provided you with background information.

In 2003, the Governor's Interagency Unintended Pregnancy Prevention Workgroup was established to improve state agency communication and coordination on initiatives to support the prevention of unintended pregnancy. This led to the 2007 development of the Governor's Blueprint for Preventing Unintended Pregnancies in the State of Michigan. The blueprint was comprised of four initiatives whose objectives were to increase public knowledge related to avoiding an unintended pregnancy, expand and improve coverage for family planning and challenge and engage Michigan's health care community in a statewide effort to reduce Michigan's unintended pregnancy rate. Three of the four initiatives, Plan First, Talk Easy and Talk Often, and the creation and dissemination of a Michigan Quality Improvement Consortium Clinical Guideline for Preventing Unintended Pregnancy in Adults have been implemented. The fourth initiative, Contraceptive Equity has yet to be achieved.

The Governor has called upon the legislature to require that health plans that cover prescription drugs also cover birth control.

On April 20, 2006, the Michigan Civil Rights Commission issued a declaratory ruling on contraceptive equity stating that Michigan employers violate the Elliot-Larsen Civil Rights Act if the employer excludes contraceptive coverage in an employer – provided comprehensive health plan that provides prescription drug coverage.

Governor's Interagency Unintended Pregnancy Prevention Workgroup

Purpose
This workgroup was established in 2003 to improve state agency communication and coordination on initiatives to support the prevention of unintended pregnancy. The workgroup is composed of policy-level representatives from key state agencies addressing this issue.

Governor's Blueprint for Preventing Unintended Pregnancies State of Michigan 2007

Objective 1:
Increase public knowledge related to avoiding an unintended pregnancy.

A. Develop public awareness and education campaign that supports the outcome of "Every Pregnancy is an Intended Pregnancy."

B. Expand age-appropriate abstinence-based prevention and risk reduction education programs for adolescents and parents in schools and community settings.

Objective 2:
Expand and improve coverage for family planning.

A. Assure all men and women of childbearing age have access to family planning services. Expand Medicaid eligibility for family planning services to women of childbearing age without insurance coverage, whose family income is at or below 185% of poverty.

B. Ensure that all women and men have ready access to the full range of contraceptive options, including all injectable/hormonal contraceptives to increase the likelihood that each sexually active man or woman who does not choose to become pregnant has an available contraceptive method that is most convenient and which she/he is willing to use.

Objective 3:
Challenge and engage Michigan's health care community in a statewide effort to reduce Michigan's unintended pregnancy rate.

A. Encourage all health plans and providers to include discussion about woman's/partner's intentions to become pregnant at every health care visit.

B. Train and encourage all health care providers and professionals, hospitals, college health clinics, local health departments, medical clinics and shelters on how to advise all women of childbearing age and men regarding accessible family planning providers and options.

C. Target health professional education programs to better teach incoming practitioners how to more effectively assist women to avoid unintended pregnancy.

The first four initiatives of the Blueprint:

1. Plan First! Michigan requested and received a waiver from the federal government to allow expanded access to family planning through Medicaid, for women earning up to 185% of the poverty level. This expansion is the Plan First! program. Since Plan First! was introduced in July 2006, more than 35,000 women have signed up for it. If Michigan can reduce the number of unintended pregnancies by only 10 percent, it would save the state more than $27 million annually.

2. Talk Early & Talk Often The program helps parents of middle school children develop the necessary skills to talk to their children about abstinence and sexuality. Since it began in October 2005, more than 70 workshops have been held throughout Michigan in public and parochial schools, medical centers, worship centers, health departments, and libraries.

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The Governor has called upon the legislature to require that health plans that cover prescription drugs also cover birth control.

On April 20, 2006, the Michigan Civil Rights Commission issued a declaratory ruling on contraceptive equity stating that Michigan employers violate the Elliot-Larsen Civil Rights Act if the employer excludes contraceptive coverage in an employer – provided comprehensive health plan that provides prescription drug coverage.

On January 27, 2009 Senators Jacobs and Switalski reintroduced Senate Bills 41 and 42 as Senate Bill 64 which requires that health plans provide prescription coverage for any prescribed drug or device approved by the United State Food and Drug Administration for use as a contraceptive.

The passage of the Women's Health and Pregnancy Prevention Package is a moral issue (not an economic one). We (MSMS, MCMCH, MOASH and MSACOG) need you to pass this package for the benefit of our patients, our families and our communities!

Thank you.

Governor's Interagency Unintended Pregnancy Prevention Workgroup

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2. Talk Early & Talk Often The program helps parents of middle school children develop the necessary skills to talk to their children about abstinence and sexuality. Since it began in October 2005, more than 70 workshops have been held throughout Michigan in public and parochial schools, medical centers, worship centers, health departments, and libraries.

3. Contraceptive Equity The Governor has called upon the legislature to require that health plans that cover prescription drugs also cover birth control. Also, the Michigan Civil Rights Commission issued a Declaratory Ruling stating that Michigan employers violate Elliott-Larsen Civil Rights Act if the employer excludes contraceptive coverage in an employer-provided comprehensive health plan that provides prescription drug coverage.

4. New Clinical Guideline Health care providers are being supported with user-friendly resources to help them engage their patients in conversation on this crucial issue, by including discussions about family planning with men and women of childbearing age, to ask them about their intentions regarding pregnancy and to provide information on family planning. A statewide advisory group of providers built a new evidence-based Clinical Guideline, approved through the Michigan Quality Improvement Consortium, and a toolkit for physicians and other providers to use in counseling their patients.

Participants:

Laurie Bechhofer, HIV/STD Education Consultant
Michigan Department of Education

Maxine Berman, Director of Special Projects
Office of the Governor

Patty Cantu, Director, Office of Career and Technical Preparation
Michigan Department of Labor and Economic Growth

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Office of the Governor

January 2008

Michigan Department Of Community Health
MDCH

DEPARTMENT OF HUMAN SERVICES

MICHIGAN Department of Education

DL E&G Michigan Department of Labor & Economic Growth

MICHIGAN CIVIL RIGHTS COMMISSION
DECLARATORY RULING ON CONTRACEPTIVE EQUITY

August 21, 2006

Request for a Declaratory Ruling

On April 20, 2006, the Michigan Civil Rights Commission (MCRC) received a request from the Michigan Chapter of the American Civil Liberties Union (MIACLU) to issue a Declaratory Ruling on contraceptive equity.

The question presented for a ruling is: Does an employer's exclusion of prescription contraceptives from a health plan that covers other prescription drugs violate the Elliott-Larsen Civil Rights Act (ELCRA)?

It is the ruling of the MCRC that an employer's exclusion of contraceptives from a health plan that covers other prescription drugs and services does violate Article 2, Section 202 of the ELCRA. To comply with this ruling, an employer in Michigan must provide full coverage for all contraceptive drugs and services if the employer's comprehensive health plan covers other drugs and services.

Background and General Information

We define contraceptive equity to mean that an employer cannot exclude coverage of prescription contraceptives from its otherwise comprehensive health plan. By a comprehensive health plan, we mean a plan that provides preventative care, treatment, and prescription drug coverage for the insured.

Contraceptives are prescribed for reasons beyond the prevention of unintended pregnancy. Contraceptives are used to treat a variety of medical conditions including amenorrhea[1], dysmenorrhea[2], Mittelschmerz[3], endometriosis[4], and acne. In addition,

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1 Absence of periods, Stedman's Online Medical Dictionary, www.stedmans.com/Atwork/section.cfm/ (accessed July 26, 2006)

contraceptives are prescribed to prevent the inherent risks associated with pregnancy. Some women, including those with histories of multiple miscarriages, cancer, smoking, are overweight, or over age 35, have a higher risk of developing a dangerous condition like gestational diabetes, preeclampsia, or ectopic pregnancy during gestation. However, doctors can use a woman's medical history and health to determine if she may be at a higher risk for developing one of these conditions. If she is, the doctor may advise her to use contraceptives because the risk to her health and the likelihood of an unsuccessful outcome are too great.

As with any medication, provider services and care are necessary to ensure proper usage, success, and length of treatment. It follows, then, that contraceptives should be included in a comprehensive health plan because they are used in the prevention and treatment of medical conditions. Currently, there are no prescription-required contraceptives for men. Therefore, all medically prescribed contraceptives are provided for women. Typically, a woman pays $40 per month for the cheapest form of prescribed contraceptives—oral pills[5].

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2 Painful menstrual cramps, Stedman's Online Medical Dictionary, www.stedmans.com/Atwork/section.cfm/ (accessed July 26, 2006).

3 Painful ovulation, Stedman's Online Medical Dictionary, www.stedmans.com/Atwork/section.cfm/ (accessed July 26, 2006).

4 Painful menstruation with heavy bleeding, Stedman's Online Medical Dictionary, www.stedmans.com/Atwork/section.cfm/ (accessed July 26, 2006).

5 This figure represents the listed price for Ortho Tri-Cyclen at Walgreen's Pharmacy in Lansing, MI on June 28th, 2006.

ELLIOTT-LARSEN CIVIL RIGHTS ACT

In Michigan, employer provided health plans are protected from unlawful employment practices by the ELCRA. Section 201(a) of ELCRA states that an "employer" is a person who has one or more employees or agents.

Section 201(d) states that "sex" includes, but is not limited to, *pregnancy, childbirth, or a medical condition related to pregnancy or childbirth* (emphasis added).

Section 202(1) states that an employer shall not … otherwise discriminate against an individual with respect to *employment, compensation, or a term, condition, or privilege of employment*, because of … sex (emphasis added).

DISCUSSION

The language of ELCRA clearly prohibits employers from excluding prescription contraceptive coverage. Such an exclusion would mean that the employer is treating women differently based on sex. This is the same conclusion the EEOC and federal courts reached by using the plain language of Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act of 1978[6]. Michigan courts have long held that because the language of the ELCRA and Title VII "strongly parallel" each other and are similar in function and scope, it is permissible to look to federal precedent and EEOC decisions for guidance in interpreting Michigan Law, *Radtke v. Everett*, 442 Mich 368, 385; 501 NW2d 155 (1993), *Dep't of Civil Rights v. Horizon Tube Fabricating Inc.*, 148 Mich App 633; 385 NW2d 685 (1986), and *Arold v. Michigan Bell Telephone Co.* WL1997575 (1998).

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[6] Refer to 42 U.S.C.A. §2000e-2(a)(1) and (k) for exact language.

The EEOC is the federal administrative body charged with enforcing Title VII. In December 2000, the EEOC formally announced that exclusion of prescription contraceptives from an otherwise comprehensive health plan constituted unlawful employment discrimination, www.eeoc.gov/policy/docs/decision-contraception.html. The EEOC based its decision on the language of Title VII, especially as amended by the Pregnancy Discrimination Act of 1978 (PDA). Under Title VII, like the ELCRA, "pregnancy, childbirth, or related medical conditions" are included in the definition of "sex" and are thus protected from employment discrimination. Furthermore, the Supreme Court declared that the PDA prohibits discrimination based on a woman's *ability* to become pregnant, *UAW v. Johnson Controls*, 499 US 187; 211, 111 S Ct 1196 (1991), emphasis added. When an employer excludes prescription coverage of contraceptives from an otherwise comprehensive health plan, the employer is discriminating against women. Contraceptives are prescribed only for women, and are principally used to control a woman's ability to decide if and when she wishes to become pregnant. Exclusion of contraceptives becomes more obvious when, as is often the case, a health plan covers medication like Viagra, a prescription used solely by men.

The EEOC rejected the argument that contraceptives were different from other prescriptions covered under an otherwise comprehensive health plan because those drugs were used to treat "abnormal conditions," and pregnancy is not abnormal (EEOC Decision, part B). "Pregnancy itself is a medical condition that poses risks to, and consequences for, a woman," *supra*. A cholesterol-reducing medication will treat high cholesterol, but it also decreases the chances of having a heart attack and related

complications of high cholesterol. Contraceptives do the same thing. They prevent pregnancy while taken, but also prevent a variety of associated risks.

Additionally, the EEOC declared that using prescription contraceptives for medical reasons other than to prevent pregnancy and pregnancy related risks are protected, *supra.* If an employer provides comprehensive coverage for an array of treatments and preventative care, they cannot exclude prescription coverage of contraceptives.

Several federal courts cited the EEOC's December 2000 ruling in their opinions. The courts used the ruling as guidance for holding the employer in the litigation liable for gender discrimination for failing to include prescription contraceptives in its otherwise comprehensive health plan, *Erickson v. The Bartell Drug Company*, 141 F Supp 2d 1266 (2001), *In re Union Pacific R.R. Employment Practices Litigation*, 378 F Supp 2d 1139 (2005). In addition to the EEOC Ruling, the two courts relied on the language of Title VII as amended by the PDA in justifying their holdings, *supra.*

The reasoning of the court in *Erickson* is instructive. In this case, the employer excluded contraceptives completely from its health plan, but provided coverage for a variety of other prescriptions such as drugs designed to prevent and treat blood-clotting, to lower blood pressure, and for smoking cessation, *Erickson* at 1268, FN1. The court detailed the language of Title VII and the legislative intent to explicitly include "pregnancy and related medical conditions" as protected from unlawful sex-based discrimination, *supra* at 1268-1271. The court held that if the health plan is otherwise comprehensive, the employer must provide coverage for all FDA approved prescription contraceptives and related services *to the same extent and terms* as other drugs, devices,

and services covered by the health plan, *supra* at 1277. The court did state that exclusion of contraceptives was discriminatory only if the employer has an otherwise comprehensive health plan, *supra* at 1272. If the employer does not provide a comprehensive plan, then it would not be unlawful to exclude contraceptives from the plan.

A second court used the same rationale as the *Erickson* court in holding that an employer discriminated against women because it excluded coverage of contraceptives for preventative purposes, *Union Pacific Railroad.* Unlike the Bartell Drug Company, Union Pacific Railroad covered contraceptives used for "non-contraceptive purpose[s]." *Union Pacific Railroad* at 1142. Female employees alleged, and the court agreed, that it was discriminatory to limit prescription contraceptive coverage. As in *Erickson*, the court based its decision on the EEOC Ruling and the plain language of Title VII and the PDA.

The court rejected the Defendant's cost argument and said that although some net increase in cost *may* occur, it cannot justify discrimination, *supra* at 1145, FN14. The court also rejected the argument that contraceptive coverage was similar to infertility treatments (which do not have to be covered in a health plan). Unlike infertility, which affects both men and women, only women can become pregnant. Excluding contraceptives affects only women, and that is why it is a discriminatory employment practice, *supra* at 1146. It is not discriminatory, though, for an employer to exclude infertility treatment for all of its employees.

Additionally, the court quoted the language of an expert witness who described a gender-neutral hypothetical medical condition that detailed potential risks associated with

pregnancy. The hypothetical highlighted the value of contraceptives in the context of preventing the potentially fatal risks of pregnancy. This analysis supports the fact that prescription contraceptives may be used to prevent and treat numerous medical conditions in the same way as non-contraceptive drugs.

RELIGIOUS EXEMPTION

Although it is discriminatory to exclude prescription contraceptives from an otherwise comprehensive health plan, an exception should be made for certain religious employers. Of the 23 states that passed contraceptive equity legislation, the majority include a religious exemption[7].

For our purposes, a "religious employer" is an entity for which all the following are true:

(a) The entity is a nonprofit organization as defined under section 501(c)(3) of the Internal Revenue Code of 1986, as amended.

(b) The inculcation of religious values is the purpose of the entity.

(c) The entity primarily employs people who share the religious tenets of the entity.

(d) The entity serves primarily persons who share the religious tenets of the entity.

This definition is used by most states with a religious exemption.

The exemption means that certain entities, while owned or operated by a religious organization, will not qualify for an exemption if they provide services to the general public. Examples include hospitals and charitable organizations that assist the general public. By narrowing the definition of a religious employer to those entities that only employ and serve a majority of people who share the same religious tenets, the provision

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[7] National Women's Law Canter, *Contraceptive Equity Laws in Your State*, August 2005 Report.

of an exemption recognizes the supremacy of the law, but still provides a way for an entity that is limited in scope to not compromise religious beliefs. An example would be a private religious school or college that only employed members with certain religious values and where religion was a core value that was inextricably linked with all aspects of the school. However, a hospital or charitable organization operates on a larger scale. These institutions service the general public and employ individuals with diverse religious beliefs. It cannot be assumed that a majority of individuals employed by this type of religious entity, nor those whom the entity serves, share common religious tenets.

CONCLUSION

The clear language of the ELCRA prohibits discrimination based upon a woman's ability to become pregnant. Exclusion of contraceptives from an otherwise comprehensive health plan targets women unfairly because only women are directly affected by pregnancy. The MCRC formally recognizes this exclusion as an unlawful employment practice. The MCRC's position is consistent not only with ELCRA, but also with the EEOC's position and federal court opinions holding that exclusion of prescription contraceptives is discriminatory. By issuing this Declaratory Ruling, all employers in Michigan are now subject to the same requirements that currently exist for employers covered under Title VII.

The U.S. Equal Employment Opportunity Commission

The following Commission Decision finds reasonable cause to believe that discrimination occured under Title VII of the Civil Rights Act of 1964, as amended, in two charges challenging the exclusion of prescription contraceptives from a health insurance plan. The Decision is a formal statement of Commission policy as applied to the facts at issue in these charges.

Decision

Summary of Charge

The Charging Parties, female employees of Respondents, allege that Respondents have engaged in an unlawful employment practice in violation of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000e *et seq.* (Title VII). Specifically, Charging Parties challenge Respondents' failure to offer insurance coverage for the cost of prescription contraceptive drugs and devices.

Jurisdiction

Respondents are employers within the meaning of Section 701(b) of the Act. All other jurisdictional requirements have also been met.

Summary of Investigation

Charging Party A, a registered nurse, began working for Respondent A in 1997. Under its health insurance plan, Respondent A covers numerous medical treatments and services, including prescription drugs; vaccinations; preventive medical care for children and adults, including pap smears and routine mammograms for women; and preventive dental care. Respondent A also covers the cost of surgical means of contraception, namely vasectomies and tubal ligations. However, Respondent A's plan excludes coverage for prescription contraceptive drugs and devices, whether they are used for birth control or for other medical purposes.

Charging Party A wishes to use oral contraceptives for birth control purposes. Based on her medical history, Charging Party A also wishes to use oral contraceptives to alleviate the symptoms of dysmenorrhea and pre-menstrual syndrome and to prevent the development of ovarian cancer.

Charging Party B, a registered nurse, began her employment with Respondent B on May 1, 1999. Respondent B is commonly owned with Respondent A, and offers to its employees the same health insurance policy that Respondent A offers to its employees. As a result, Charging Party B is subject to the same exclusions from health coverage as Charging Party A. Charging Party B wishes to use Depo Provera, an injectible prescription contraceptive, for birth control purposes.

Charging Parties both allege that Respondents' failure to offer coverage for prescription contraceptive drugs and devices constitutes discrimination on the bases of sex and pregnancy in violation of Title VII. Respondents deny that the exclusion of prescription contraceptives, which on its face does not distinguish between men and women, is discriminatory.

Discussion

Based on current medical knowledge, individuals who wish to avoid conception may choose from a range of contraceptive alternatives. These alternatives include surgical procedures, like vasectomies and tubal ligations; non-prescription birth control, like condoms; and prescription contraceptive drugs and devices, like birth control pills, diaphragms, intra-uterine devices, and Norplant implants. Prescription contraceptives are available only to women.

Oral contraceptives are also widely recognized as effective in treating certain medical conditions that exclusively affect women, such as dysmenorrhea (menstrual cramps) and pre-menstrual syndrome.[1] Contraceptives are also sometimes prescribed to prevent the development of ovarian cancer. Respondents' insurance plan excludes contraceptives "regardless of intended use."[2]

The Commission concludes that Respondents' exclusion of prescription contraceptives violates Title VII, as amended by the Pregnancy Discrimination Act,[3] whether the contraceptives are used for birth control or for other medical purposes.

I. Exclusion of Prescription Contraceptives Used for Birth Control Purposes

A. The Pregnancy Discrimination Act Applies to Prescription Contraception

To clarify its long-standing intent with regard to Title VII, Congress enacted the Pregnancy Discrimination Act (PDA) to explicitly require equal treatment of women "affected by pregnancy, childbirth, or related medical conditions" in all aspects of employment, including the receipt of fringe benefits.[4] This language bars employers from treating women who are pregnant or affected by related medical conditions differently from others who are similarly able or unable to work. It also prohibits employers from singling out pregnancy or related medical conditions in their benefit plans.

As the Supreme Court has made clear, the PDA's prohibitions cover a woman's potential for pregnancy, as well as pregnancy itself. Recognizing that the PDA prohibits "discrimination on the basis of a woman's ability to become pregnant," the Court concluded that an employment policy that excluded women capable of bearing children from certain jobs was an impermissible classification because it was based on the potential for pregnancy. As the Court held, "[u]nder the PDA, such a classification must be regarded, for Title VII purposes, in the same light as explicit sex discrimination."[5] Under the Court's analysis, the fact that it is women, rather than men, who have the ability to become pregnant cannot be used to penalize them in any way, including in the terms and conditions of their employment.

Contraception is a means by which a woman controls her ability to become pregnant. The PDA's prohibition on discrimination against women based on their ability to become pregnant thus necessarily includes a prohibition on discrimination related to a woman's use of contraceptives. Under the PDA, for example, Respondents could not discharge an employee from her job because she uses contraceptives. So, too, Respondents may not discriminate in their health insurance plan by denying benefits for prescription contraceptives when they provide benefits for comparable drugs and devices.

This conclusion is supported by additional language in the PDA that specifically exempts employers from any obligation to offer health benefits for abortion in most circumstances.[6] Congress understood that absent an explicit exemption, the PDA would require coverage of medical expenses resulting from a woman's decision to terminate a pregnancy.

The same analysis applies to the question of whether the PDA covers prescription contraceptives. As just discussed, the PDA's prohibition of discrimination in connection with a woman's ability to become pregnant necessarily includes the denial of benefits for contraception. Had Congress meant to limit the applicability of the PDA to contraception, therefore, it would have enacted a statutory exemption similar to the abortion exemption. Such an exemption, of course, does not exist for contraceptives.

Further, construing the PDA to cover contraception implements Congress' clearly expressed intent in enacting the PDA. Congress wanted to equalize employment opportunities for men and women, and to address discrimination against female employees that was based on assumptions that they would become pregnant.[7] Congress thus prohibited discrimination against women based on "the whole range of matters concerning the childbearing process,"[8] and gave women "the right ... to be financially and legally protected before, during, and after [their] pregnancies."[9] It was only by extending such protection that Congress could ensure that women would not be disadvantaged in the workplace either because of their pregnancies or because of their ability to bear children.

In sum, the Commission concludes that the PDA covers contraception based on its plain language, the Supreme Court's interpretation of the statute, and Congress' clearly expressed legislative intent.

B. The PDA Requires Coverage of Prescription Contraceptives in this Case

The PDA requires that expenses related to pregnancy, childbirth, or related medical conditions be treated the same as expenses related to other medical conditions.[10] Because Respondents have failed to provide such equal treatment in this case, they are liable for discrimination under the PDA.

Contraception is a means to prevent, and to control the timing of, the medical condition of pregnancy. In evaluating whether Respondents have provided equal insurance coverage for prescription contraceptives, therefore, the Commission looks to Respondents' coverage of other prescription drugs and devices, or other types of services, that are used to prevent the occurrence of other medical conditions. In Respondents' plan, such drugs, devices, and services include:

- vaccinations;

- drugs to prevent development of medical conditions, such as those to lower or maintain blood pressure or cholesterol levels;
- anorectics (weight loss drugs) for those 18 years of age and under;
- preventive care for children and adults, including physical examinations; laboratory services in connection with such examinations; x-rays; and other screening tests, like pap smears and routine mammograms; and
- preventive dental care (including oral examinations, tooth cleaning, bite wing x-rays, and fluoride treatments).(11)

Respondents have made three arguments to justify their exclusion. First, Respondents allege that their plan covers treatment of medical conditions only if "there is something abnormal about [the employee's] mental or physical health,"(12) and thus that the above-listed drugs and services are not appropriate comparators for evaluating Respondents' coverage of contraceptives. However, this argument reflects a misunderstanding about the nature of pregnancy. It is widely recognized in the medical community that pregnancy is a medical condition that poses risks to, and consequences for, a woman.(13)

In addition, Respondents' argument is also belied by the explicit terms of their health plan, which is not, in fact, restricted to coverage of "abnormal" conditions. First, Respondents cover contraception through surgical forms of sterilization - vasectomies and tubal ligations -- without requiring any showing of the reasons individuals are undergoing the procedures. More broadly, Respondents cover numerous treatments and services that are designed to maintain current health and prevent the occurrence of future medical conditions, whether or not there is something "abnormal" about the employee's current health status. It is appropriate, for example, to compare Respondents' coverage of vaccinations or physical examinations to that of contraceptives, because both serve the same preventive purposes. Because Respondents have treated contraception differently from preventive treatments and services for other medical conditions, they have discriminated on the basis of pregnancy.(14)

Respondents also claim that Charging Parties' claims are preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1144(a), 1191.(15) This claim is without merit. ERISA preempts certain *state* laws that regulate insurance, but explicitly exempts federal law from preemption.(16) Moreover, the fact that ERISA does not require health plans to "provide specific benefits" does not mean that other statutes - namely Title VII - do not impose such requirements where necessary to avoid or correct discrimination.

Finally, Respondents state that they have excluded contraception for "strictly financial reasons."(17) Respondents' motivation is, however, legally irrelevant. Although Congress clearly anticipated that an employer's insurance costs would likely increase once the PDA required employers to cover pregnancy and related medical conditions,(18) it wrote no cost defense into the law.(19)

II. Exclusion of Prescription Contraceptives Used for Birth Control and/or Other Medical Purposes

The analysis set forth above applies to Charging Parties' claims that Respondents' exclusion unlawfully interferes with their ability to use prescription contraceptives for birth control purposes. Charging Party A has further claimed that Respondents' exclusion applies not only to her use of contraceptives for birth control purposes, but also to her use of contraceptives to treat dysmenorrhea and menstrual cramps. Respondents have violated Title VII's basic nondiscrimination principles regardless of the purpose of Charging Parties' use of contraceptives.

Respondents assert that their exclusion does not constitute sex discrimination because it does not explicitly distinguish between men and women.(20) However, prescription contraceptives are available *only* for women. As a result, Respondents' explicit refusal to offer insurance coverage for them is, by definition, a sex-based exclusion. Because 100 percent of the people affected by Respondent's policy are members of the same protected group - here, women -- Respondent's policy need not specifically refer to that group in order to be facially discriminatory.(21)

Moreover, Respondents' other efforts to mount a defense are unavailing. Respondents may not rely on arguments that coverage of contraception is precluded by ERISA or may be denied based on cost concerns. Nor can Respondents successfully argue that contraception is not medically necessary, whether used for birth control or other medical purposes. *See* Section I(B), *supra*.

The inequality in treatment is apparent whether Charging Parties wish to use contraceptives to prevent conception or for other medical purposes. This is because Respondents have circumscribed the treatment options available to women, but not to men. Respondents' health plan effectively covers approved, non-experimental treatments for employees' medical conditions *unless* those treatments involve contraceptives. This is unlawful.(22)

Conclusion

There is reasonable cause to believe that Respondents have engaged in an unlawful employment practice in violation of Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act, by failing to offer insurance coverage for the cost of prescription contraceptive drugs and devices. Charging Parties are entitled to reimbursement of the costs of their prescription contraceptives for the applicable back pay period. In addition, the District Office is instructed to determine whether any cognizable damages have resulted from Respondents' actions.

In order to avoid violating Title VII in the future:

- Respondents must cover the expenses of prescription contraceptives to the same extent, and on the same terms, that they cover the expenses of the types of drugs, devices, and preventive care identified above. Respondents must also offer the same coverage for contraception-related outpatient services as are offered for other outpatient services. Where a woman visits her doctor to obtain a prescription for contraceptives, she must be afforded the same coverage that would apply if she, or any other employee, had consulted a doctor for other preventive or health maintenance services. Where, on the other hand, Respondents limit coverage of comparable drugs or services (*e.g.*, by imposing maximum payable benefits), those limits may be applied to contraception as well.
- Respondents' coverage must extend to the full range of prescription contraceptive choices. Because the health needs of women may change -- and because different women may need different prescription contraceptives at different times in their lives -- Respondents must cover each of the available options for prescription contraception. Moreover, Respondents must include such coverage in each of the health plan choices that it offers to its employees. *See* 29 C.F.R. part 1604, App. Q&A 24; *Arizona Governing Committee v. Norris*, 463 U.S. 1073, 1081-82 n.10 (1983).

The charges are remanded to the field for further processing in accordance with this decision.

FOR THE COMMISSION:

12/14/00
Date

/s/
Executive Officer
Executive Secretariat

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1. *See, e.g.*, Kaunitz, *Oral Contraceptive Health Benefits: Perception v. Reality*, Contraception 1999, 59:29S-33S (January 1999); Sulak, *Oral Contraceptives: Therapeutic Uses and Quality -of-Life Benefits - Case Presentations*, Contraception 1999, 59:35S-38S (January 1999).

2. Letter from Respondents to EEOC, June 22, 2000.

3. Numerous states have also addressed policies like Respondents'. To date, thirteen states have passed legislation mandating insurance coverage of contraception where a policy covers prescription drugs or devices. *See* Cal. Ins. Code 10123.196 (California); Del. Code Ann., title 18, 3559 (Delaware); 1999 Conn. Acts 99-79 (June 3, 1999) (Connecticut); Ga. Code Ann. 33-24-59.6 (Georgia); Hawaii Rev. Stat. 431:10A-116.6, 431:10A-116.7, 432:1-604.5 (Hawaii); Iowa Code 514C.19; Me. Rev. Stat. Ann., title 24, 2332-J, Me. Rev. Stat. Ann., title 24-A, 2756, 2847-G, 4247 (Maine); Md. Code Ann., Ins., 15-826 (Maryland); Nev. Rev. Stat. Ann. 689A.0415 *et seq.* (Nevada); N.H. Rev. Stat. Ann., title 37, 415:18-i (New Hampshire); 1999 N.C. Sess. Laws 90 (June 30, 1999) (North Carolina); R.I. Gen. Laws 27-18-57, 27-19-48, 27-20-43, 27-41-59 (Rhode Island); 8 Vt. Stat. Ann. 4099c (Vermont). Insurance plans offered to federal employees must meet similar requirements. P.L. 106-58, 113 Stat. 430 (Sept. 29, 1999).

4. 42 U.S.C. 2000e(k).

5. *Int'l Union, UAW v. Johnson Controls*, 499 U.S. 187, 199, 211 (1991).

6. 42 U.S.C. 2000e(k).

7. H.R. Rep. No. 948, 95th Cong., 2d Sess. 3 (1978) ("[t]he assumption that women will become pregnant and leave the labor force leads to the view of women as marginal workers, and is at the root of the discriminatory practices which keep women in low-paying and dead-end jobs"); *see also id.* at 6-7; 123 Cong. Rec. 29,385 (1977) (statement of Senator Williams, chief sponsor of the Senate bill that led to the PDA) ("[b]ecause of their capacity to become pregnant, women have been viewed as marginal workers not deserving of the full benefits of compensation and advancement . . .").

8. H.R. Rep. No. 948, 95th Cong., 2d Sess. 5 (1978).

9. 124 Cong. Rec. H38,574 (daily ed. October 14, 1978) (statement of Rep. Sarasin, a manager of the House version of the PDA).

10. *See, e.g.*, 29 C.F.R. Part 1604, App. Introduction ("any health insurance provided must cover expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions").

11. *See* Respondents' Summary Plan Description at, *e.g.*, pp. 87, 90, 112, 137.

12. Letter from Respondents to EEOC, June 22, 2000.

13. *See, e.g., Equity in Prescription Insurance and Contraceptive Coverage Act 1998: Hearings on S. 766 before the Senate Committee on Labor and Human Resources*, 105th Cong., 2d Sess. 25 (1998) (statement of Richard H. Schwarz, M.D.); 144 Cong. Rec. S9,194 (daily ed. July 29, 1998) (statement of Senator Snowe) (there is "nothing 'optional' about contraception. It is a medical necessity for women during 30 years of their lifespan. To ignore the health benefits of contraception is to say that the alternative of 12 to 15 pregnancies during a woman's lifetime is medically acceptable.") (quoting statement by American College of Obstetricians and Gynecologists).

14. In addition, Respondents cover Viagra where patients complain about "decreased sexual interest or energy," whether or not the individual has been diagnosed as impotent. Letter from Respondents to EEOC, August 25, 2000. Respondents' assertion that their plan covers treatments only for abnormal medical conditions is not credible in light of these facts.

15. Letter from Respondents to EEOC, June 22, 2000.

16. 29 U.S.C. 1144(a) (setting forth basic rule of preemption of state law); 1144(d) ("[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law"); *see also Shaw v. Delta Airlines*, 463 U.S. 85 (1983) (state laws that are co-extensive with federal laws are not preempted by ERISA).

17. Letter from Respondents to EEOC, April 19, 2000.

18. *See, e.g.*, Statement of Senator Williams, floor manager of the PDA, *reprinted in* "Legislative History of the Pregnancy Discrimination Act of 1978," at 63, 64 (1980) (identifying "significant cost factor[s]" that would be incurred by employers, but noting that "the committee found that the cost of equal treatment of pregnancy has been greatly exaggerated"); H. Rep. No. 95-948, 95th Cong., 2d Sess. 10 (1978) (discussing anticipated costs of complying with PDA). In any event, the costs of contraception are low. *See* Alan Guttmacher Institute, *Cost to Employer Health Plans of Covering Contraceptives* (June 1998) (estimating that average added cost to employers of covering contraceptives is $1.43 per employee per month). Moreover, studies -- and common sense -- show that the financial costs associated with childbirth are much greater than the costs of many years of contraception. *See* Law, *Sex Discrimination and Insurance for Contraception*, 73 Wash. L. Rev. 363, 365 & n. 13 (1998) (citing studies). Even if a cost defense were available as a matter of law, therefore, Respondents would be unlikely to be able to cost-justify the exclusion of contraceptives.

19. *See Arizona Governing Committee v. Norris*, 463 U.S. 1073, 1085 n. 14 (1983) (in enacting the PDA, Congress decided "to forbid special treatment of pregnancy despite the special costs associated therewith . . ."); *Newport News Shipbuilding and Dry Dock Co. v. EEOC*, 462 U.S. 669, 683 n. 26 (1983) ("no [cost] justification is recognized under Title VII once discrimination has been shown").

20. Letter from Respondents to EEOC, June 22, 2000.

21. This is the rationale that was set forth by the dissenters in *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), and adopted by Congress in passing the PDA. *See Gilbert*, 429 U.S. at 149 (Brennan, J., dissenting) ("it offends common sense to suggest that a classification revolving around pregnancy is not, at the minimum, strongly 'sex related'"); *id.* at 162 (Stevens, J., dissenting) (special treatment of pregnancy is sex discrimination because it is "the capacity to become pregnant which primarily differentiates the female from the male"); H.R. Rep. No. 948, 95th Cong., 2d Sess. 2 (1978) (adopting reasoning of dissenters). *See also Newport News Shipbuilding and Dry Dock Co. v. EEOC*, 462 U.S. 669, 676 (1983) ("Congress, by enacting the [PDA], not only overturned the specific holding in [*Gilbert*], but also rejected the test of discrimination employed by the Court in that case"); *California Federal Savings & Loan Ass'n v. Guerra*, 479 U.S. 272, 284 (1987) (in enacting the PDA, Congress "unambiguously expressed its disapproval of both the holding and the reasoning of the Court in" *Gilbert*) (citation omitted).

22. Of course, as has been recognized by legal commentators, an employer's exclusion of contraceptives can also be

challenged on disparate impact grounds. Law, *Sex Discrimination and Insurance for Contraception*, 73 Wash. L. Rev. 363, 373-76 (1998). Based on the analysis in text, however, it is unnecessary to address application of the disparate impact theory here.

This page was last modified on December 14, 2000.


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SENATE BILL No. 64

January 27, 2009, Introduced by Senators JACOBS and SWITALSKI and referred to the Committee on Health Policy.

A bill to amend 1980 PA 350, entitled

"The nonprofit health care corporation reform act,"

(MCL 550.1101 to 550.1704) by adding section 416e.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 416E. (1) A HEALTH CARE CORPORATION GROUP OR NONGROUP CERTIFICATE THAT PROVIDES PRESCRIPTION COVERAGE SHALL INCLUDE COVERAGE FOR ANY PRESCRIBED DRUG OR DEVICE APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION FOR USE AS A CONTRACEPTIVE.

(2) COVERAGE UNDER SUBSECTION (1) SHALL NOT BE SUBJECT TO ANY DOLLAR LIMIT, COPAYMENT, DEDUCTIBLE, OR COINSURANCE PROVISION THAT DOES NOT APPLY TO PRESCRIPTION COVERAGE GENERALLY.

Enacting section 1. This amendatory act takes effect January 1, 2010.

SENATE BILL No. 64

SENATE BILL No. 41

January 24, 2007, Introduced by Senators SCOTT and JACOBS and referred to the Committee on Health Policy.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

(MCL 500.100 to 500.8302) by adding section 3406s.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 3406S. (1) AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY OR CERTIFICATE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE THAT PROVIDES PRESCRIPTION COVERAGE AND A HEALTH MAINTENANCE ORGANIZATION GROUP OR INDIVIDUAL CONTRACT THAT PROVIDES PRESCRIPTION COVERAGE SHALL INCLUDE COVERAGE FOR ANY PRESCRIBED DRUG OR DEVICE APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION FOR USE AS A CONTRACEPTIVE.

(2) COVERAGE UNDER SUBSECTION (1) SHALL NOT BE SUBJECT TO ANY DOLLAR LIMIT, COPAYMENT, DEDUCTIBLE, OR COINSURANCE PROVISION THAT DOES NOT APPLY TO PRESCRIPTION COVERAGE GENERALLY.

SENATE BILL No. 41

SENATE BILL No. 42

January 24, 2007, Introduced by Senators JACOBS and SCOTT and referred to the Committee on Health Policy.

A bill to amend 1980 PA 350, entitled

"The nonprofit health care corporation reform act,"

(MCL 550.1101 to 550.1704) by adding section 416e.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 416E. (1) A HEALTH CARE CORPORATION GROUP OR NONGROUP CERTIFICATE THAT PROVIDES PRESCRIPTION COVERAGE SHALL INCLUDE COVERAGE FOR ANY PRESCRIBED DRUG OR DEVICE APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION FOR USE AS A CONTRACEPTIVE.

(2) COVERAGE UNDER SUBSECTION (1) SHALL NOT BE SUBJECT TO ANY DOLLAR LIMIT, COPAYMENT, DEDUCTIBLE, OR COINSURANCE PROVISION THAT DOES NOT APPLY TO PRESCRIPTION COVERAGE GENERALLY.

Enacting section 1. This amendatory act takes effect January

SENATE BILL No. 42

RESOLUTION 86-08A

Title:	Contraceptive Equity
Introduced by:	Anne-Mare Ice, MD, for the Wayne County Delegation
Original Author:	Cheryl Gibson Fountain, MD
Referred to:	Reference Committee B
House Action:	Adopted

Whereas, the Governor has called upon the legislature to require that health plans that cover prescription drugs also cover birth control, and

Whereas, the Michigan Civil Rights Commission issued a Declaratory Ruling stating that Michigan employers violate the Elliott-Larsen Civil Rights Act if the employer excludes contraceptive coverage in an employer-provided comprehensive health plan that provides prescription drug coverage, and

Whereas, Senate Bills 41 and 42 require that health plans provide prescription coverage for any prescribed drug administration for use as a contraceptive were introduced on January 24, 2007, by Senators Martha Scott and Gilda Jacobs and referred to the Senate Health Policy Committee, and

Whereas, the Michigan Women's Commission supports this legislation as noted in a letter from Executive Director Judy Karandjeff; therefore be it

RESOLVED: That MSMS strongly urge the legislature to pass Senate Bills 41 and 42 to provide prescription coverage for any prescribed drug or device approved by the United States Food and Drug Administration for use as a contraceptive.

WAYS AND MEANS COMMITTEE FISCAL NOTE: NONE

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Employment:

Beaumont Hospital Grosse Pointe – Present
Beaumont Hospital Royal Oak – Present
St. John Hospital & Medical Center Present
St. John Detroit Riverview Hospital Chief of Staff – 2004-June 2007

Medical Affiliations:

President Elect Wayne County Medical Society
Michigan State Medical Society Board of Directors
Michigan Council for Maternal & Child Health Board of Directors
Michigan Section American College Obstetricians and Gynecologists Advisory Council
Detroit Regional Infant Mortality Task force
Michigan organization on Adolescent Sexual Health Board
Fellow American Board of Obstetricians & Gynecologists
National Medical Association
American Medical Association
Michigan State Medical Society
Detroit Medical Society
American Association of Gynecologic Laparoscopists
Southeastern Michigan Surgical Society
Consumer Guide's America's Top Obstetricians & Gynecologists 2002 – 2003; 2004 – 2005
Chief of Staff Boot Camp
Physician Leadership Academy
American College of Physician Executives
Healthy Mothers, Healthy Babies

Community Involvement

Member – Chain Link Ministry for Christ Church
Detroit Public Schools – Charles C. Vincent Education Center (Medical Director)
National Association for the Advancement of Colored People
American Business Women's Association – Ambassador Tri-County Chapter
Association for Females Inspired to Reach Their Maximum
Charles H. Wright, M.D., African American Museum
Author – Michigan Chronicle & Women's World Magazine
Medical Mission Ajalli, Anambra State, Nigeria
Who's Who In Black Detroit – Inagural Edition 2006
Ascension Health Perinatal Steering Committee
Governor's Blueprint for Preventing Unintended Pregnancies – Provider Task Force
St. John Health Interdisciplinary Perinatal Care Committee

Interest:

Adolescent Medicine
Teenage Pregnancy
Menopause

Michigan State Medical Society Board of Directors – 2009-2010

MSMS

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Lynn S. Gray, MD, MPH


Edwin H. Gullekson, MD


William A. Howard, MD


Jeffrey E. Jacobs, MD


Edward G. Jankowski, MD


Lonnie Joe, Jr., MD


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Narinder K. Sherma, MD

Michael W. Smith, MD

F. Remington Sprague, MD

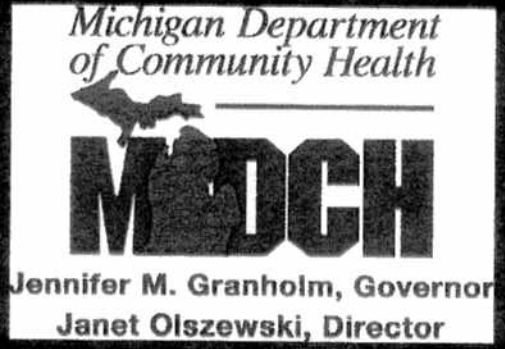
Venu Vadlamudi, MD

Carol L. van der Harst, MD

Todd K. Van Heest, MD

A New Clinical Guideline for

Preventing Unintended Pregnancy in Adults



Provider Toolkit

developed under the auspices of the

Governor's Blueprint for Preventing Unintended Pregnancies

State of Michigan, 2007

"Unintended pregnancy" means:

- Mistimed or unwanted at the time of *conception*, and does not reflect parental perception of the child at the time of *birth*.

Developed under the auspices of

The Michigan Governor's Blueprint for Preventing Unintended Pregnancies

- Increase public knowledge and skills related to avoiding an unintended pregnancy.
- Expand and improve coverage for family planning.
- Challenge and engage Michigan's health care community in a statewide effort to reduce Michigan's unintended pregnancy rate.

This Presentation Is For...

- Physicians and support staff in a variety of settings
- Family planning, Title X clinics
- Professional associations, medical societies, specialty societies
- Medical students, interns, residents
- College health professionals
- Local public health practitioners

... *No missed opportunities to talk to patients about preventing unintended pregnancies!*

This Presentation Includes…

A. Who and when? (slide 6)
B. Why? The vision & the data (slides 7-17)
C. Public-private partnership (slides 18-19)
    1. Governor's Blueprint, Provider Task Force, MQIC, others
D. What and how? (slides 20-32)
    1. Using the adult guideline
        - What about teens?
    2. Patient education & supports
        - Downloadable fact sheets
        - Plan First!
        - Patient phone numbers and websites
E. For more information (slides 33-42)
    1. Background – organizations and people
    2. Get involved!

The Guideline Is For:

- All **females** of childbearing age 18 and older
- All **males** 18 years of age and older
- **Yearly** at regular physical
- Or **more often** at provider's discretion

The Vision:

If all pregnancies were intended...

- *We would have significant reductions in infant mortality, child abuse and neglect, and Medicaid costs*
- *Abortion would be reduced (about half of unintended pregnancies result in abortion)*

1. Guttmacher Institute

Why Is It Important?

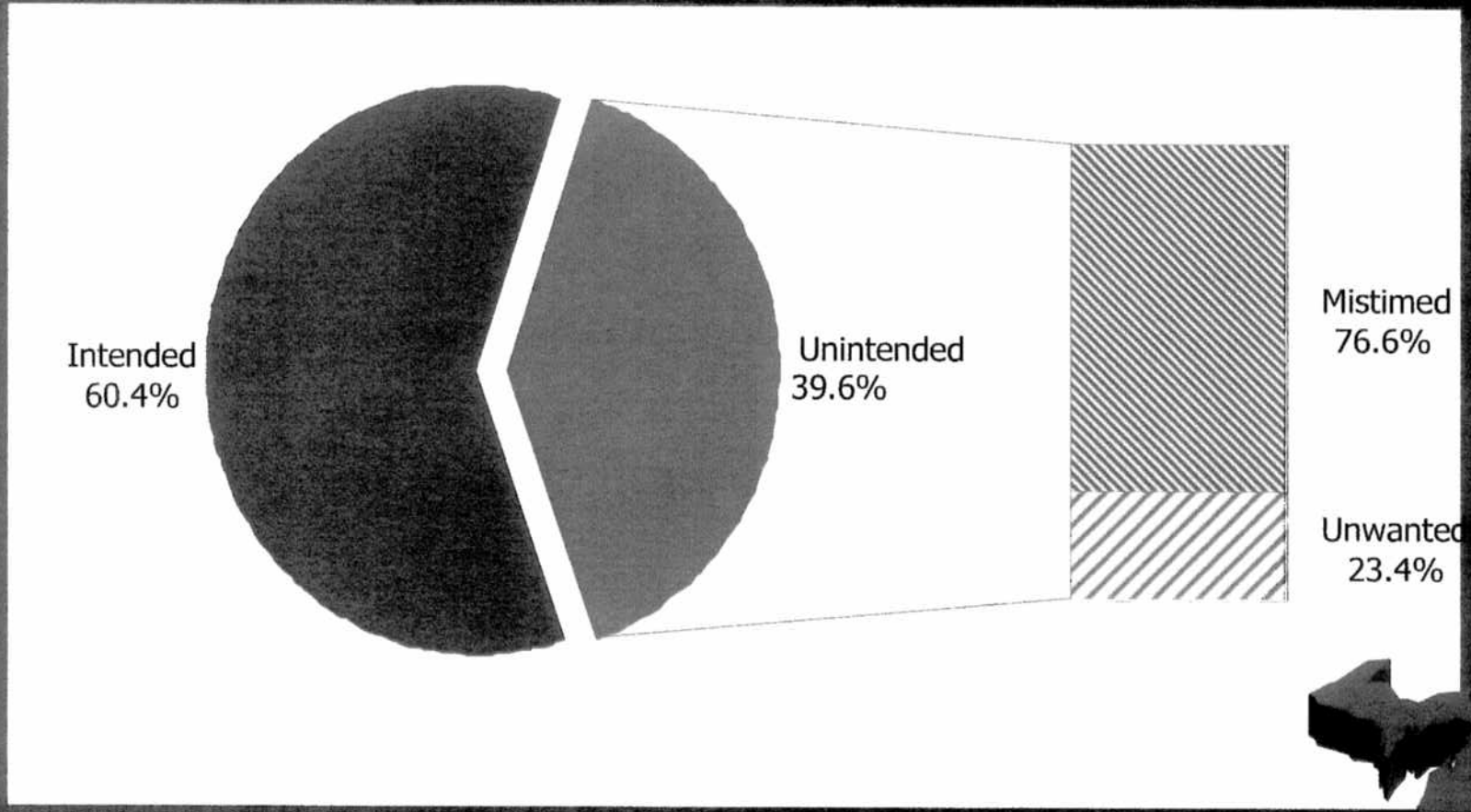
The U.S. has one of the highest unintended pregnancy rates in the industrialized world – about half of all pregnancies are unintended.

Who Is Most At Risk for Unintended Pregnancy?

- Teens have the highest *percentage* of unintended pregnancies
- Women in their twenties have the highest *number* of unintended pregnancies
- Young and impoverished women are disproportionately burdened by unintended pregnancies
- Unmarried women
- Women with an annual household income below 200% of the federal poverty level
- African American and Hispanic women
- Low-income women without contraceptive health insurance coverage are twice as likely to have an unintended pregnancy

Michigan Department of Community Health, PRAMS 2005

Unintended Pregnancies in Michigan



Almost 4 out of every 10 babies born in Michigan are unintended.

PRAMS 2004 Report, Michigan Department of Community Health, 2007

Why is it important?

Reducing **Costs**

- In FY 2000, the state Medicaid program paid for prenatal, delivery and post-natal care of about 26,000 unintended births[1]
- Each birth cost Medicaid $11,000, which translates to $286 million in costs for Michigan[1]
- If Michigan can reduce the number of unintended pregnancies by just 10%, > $27 million in Medicaid expenditures would be saved annually[1]

Every $1 spent on family planning services saves an estimated $3 in medical costs. [2]

1. Michigan Department of Community Health
2. Guttmacher Institute, http://www.guttmacher.org/pubs/tgr/06/5/gr060507.html

Why is it important?

Reducing **Abortions**

- 25,636 induced abortions were reported in Michigan in 2006, a 1.7% increase from the total of 25,209 reported in 2005 [1]
- The abortion rate in Michigan has not decreased in the past decade (between 11/1000 live births & 13/1000 live births) [2]

1. http://www.mdch.state.mi.us/PHA/OSR/abortion/intro.asp
2. http://www.mdch.state.mi.us/ PHA/OSR/abortion/Tab_A.asp

Why is it important?

Reducing **Infant Mortality**

- Unintended pregnancy is strongly correlated with increased infant mortality and morbidity
  - When the unintended pregnancy is wanted, there still may be late or lack of prenatal care
  - There is a higher incidence of unintended pregnancy in young, impoverished mothers
- Health disparity: In 2005, Michigan's infant mortality rate for infants of color was 17.9 deaths per 1,000 live births, while for whites it was 5.5 deaths per 1,000 live births [1]
- In 2004, the U.S. overall rate was 6.78 infant deaths per 1,000 births, near the bottom of industrialized countries [2]

1. http://www.mdch.state.mi.us/pha/osr/InDxMain/Tab2.aps
2. "Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set," CDC.

The New York Times

"… Singapore has the best infant mortality rate in the world: 2.3 babies die before the age of 1 for every 1,000 live births. Sweden, Japan and Iceland all have a rate that is less than half of ours. If we had a rate as good as Singapore's, we would save 18,900 babies each year."

-- Nicholas D. Kristoff, *The New York Times*

http://www.nytimes.com/2005/01/12/opinion/12kris.html?ex=1263272400&en=c7ea472ff9651976&ei=5090

Why is it important?

Increasing Opportunities for a **Healthy Pregnancy**

- Early weeks are key – if a woman knows she is pregnant she can:
  - Start timely prenatal care
  - Choose healthy foods
  - Have a healthy weight; maintain a healthy level of physical activity
  - Stop tobacco, alcohol, use of other drugs
  - Begin folic acid
  - Assess the home environment for harmful toxins
  - Be evaluated for STDs, family history, immunizations, medications, domestic violence, other risks and conditions

American College of Obstetricians and Gynecologists, http://www.acog.org/publications/patient_education/bp056.cfm

March of Dimes, http://marchofdimes.com/pnhec/173.asp

Why a Clinical Guideline? The CDC on Preconception Care.

"Several providers and maternal and child health researchers have recommended that health risks and behaviors be addressed during any encounter with the health-care system because approximately half of pregnancies in the United States are unintended … provision of preconception care can increase pregnancy planning and intention … studies have consistently demonstrated that planned pregnancies typically have improved outcomes for both women and infants."

-- MMWR, 2006

"Recommendations to Improve Preconception Health and Health Care United States," Posner et. al., MMWR, April 21 2006. http://www.cdc.gov/MMWR/preview/mmwrhtml/rr5506a1.htm

CDC Recommendations

1. Individual responsibility across the lifespan
2. Consumer awareness
3. Preventive visits
4. Interventions for identified risks,
5. Interconception care
6. Pre-pregnancy checkup
7. Health insurance coverage for women with low incomes
8. Public health programs and strategies
9. Research
10. Monitoring improvements

"Recommendations to Improve Preconception Health and Health Care United States," Posner et. al., MMWR, April 21 2006. http://www.cdc.gov/MMWR/preview/mmwrhtml/rr5506a1.htm

Public-Private Partnership: Provider Task Force

- Part of Governor's Blueprint for Preventing Unintended Pregnancies, 40-member statewide advisory group
- Under auspices of Interagency Governor's Workgroup
- Convened by Michigan Surgeon General Dr. Kimberlydawn Wisdom in September 2006
- Key leadership from Brenda Fink, Director, Division of Family and Community Health, MDCH
- Chaired by Dr. Thomas Petroff, CMO of McLaren Health Plan and chair of Michigan Assoc. of Health Plans Medical Directors
- In partnership with Michigan Quality Improvement Consortium - collaboration that ensures evidence basis, standardizes and disseminates clinical guidelines
- See "Background" section

Public-Private Partnership: Michigan Quality Improvement Consortium

... "a collaborative effort whose participants include physicians and other personnel representing the Michigan HMOs along with the Michigan State Medical Society, the Michigan Osteopathic Association, the Michigan Association of Health Plans, the Michigan Peer Review Organization and Blue Cross Blue Shield of Michigan."

For more information, see www.mqic.org

June, 2007

Michigan Quality Improvement Consortium Guideline

Prevention of Unintended Pregnancy in Adults 18 Years and Older

The following guideline recommends specific interventions for assessing and counseling to lower the risk of unintended pregnancies.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Males and Females	Assessment for risk of unintended pregnancy	**Ask** about: • Sexual activity/involvement, past pregnancy and outcome • Abuse (e.g. Were you pressured or forced to have sex when you did not want to?) • Consistent use of birth control or protection (e.g. Does it ever happen that you have sex without using birth control or protection?) - If contraception is used, assess type • Intent to become pregnant or father a child (e.g. Are you trying to get pregnant? Are you trying to father a child?) If currently pregnant discuss postpartum contraception.	At annual health exam; more frequently at the discretion of the health care provider **[D]**
	Interventions to prevent unintended pregnancies	**Advise** and discuss: • Patient's risk of pregnancy or contributing to an unintended pregnancy • Risks and adverse outcomes associated with unintended pregnancies **Assess:** • Patient's understanding of risks and readiness to make behavior changes. **Assist** patients in preventing unintended pregnancy by: • Discussing all contraceptive methods **[B]** • Offering prescriptions • Encouraging consistent latex condom use for sexually transmitted infection prevention **[B]** • Referring to primary care provider, local health department, family planning clinic, Plan First, federally qualified health center or hotline **Arrange** follow-up	

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources including the Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report: Recommendations to Improve Preconception Health and Health Care - United States, 06-Apr-2006; 55 (RR-6), (www.cdc.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Guideline Objectives

- To increase conversations between providers and patients ≥18 (men as well as women) about risks and consequences of unintended pregnancies
- To empower patients with family planning information for responsible decision-making
- To decrease unintended pregnancies in adults ages 18 and over in Michigan

The Clinical Interview

- It's effective, evidence-based ("My doctor said...")
  - Longstanding approach for prevention and chronic disease
  - Health care provider recommendation is central to patient acceptance
- It's low-intensive, low-tech, low-cost ("a conversation")

Increasing Intentionality for One of Life's Most Important Decisions

Why women who don't want to be pregnant say they have unprotected sex (focus groups):

- "Not thinking, not planning, going with the flow" (87% of those interviewed)
  - Ambivalence towards pregnancy
  - Lack of thought/preparation ('go with the flow')
  - Perceived low risk of getting pregnant
  - Shy, embarrassed to acquire contraception
  - Pre-existing condition limits choice of method
  - Reliance on alternate methods (e.g. withdrawal)
- Other reasons: method, partner-related, cost/access

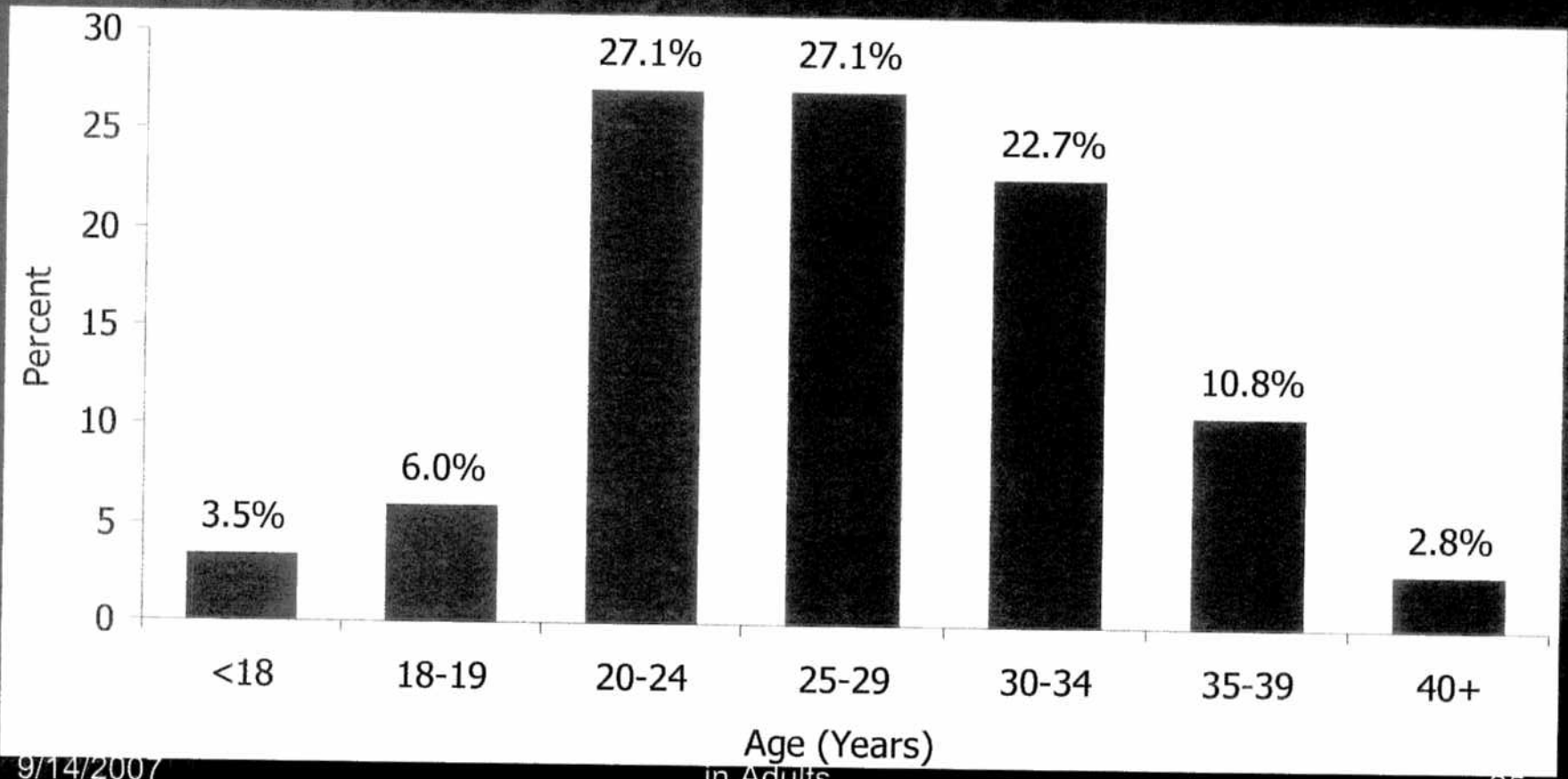
"Risking Unintended Pregnancy," Mary Nettleman, MD, MS, Adejoke Ayoola, RN, MSc, Jennifer Brewer, BA, Michigan State University, 2006.

Why Focus on Adults?

- A different approach is needed for talking with teens
- Most pregnancies in teens are unintended, but 75% of unintended pregnancies occur in adults

Less than 4% of babies born are to teens under 18.

Prevalence of maternal age, 2004 MI PRAMS



How the Guideline Can Help: Assess.

Ask About...

- Sexual activity
- Abuse
- Intention to have a child
- Birth control
  - Consistent and correct use
  - Assess current type used
  - If currently pregnant, discuss postpartum contraception

How the Guideline Can Help: **Intervene.**

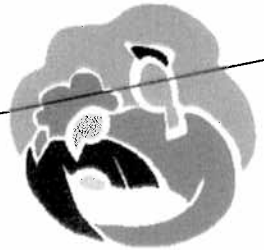
- Advise Patient about Their Risk Of:
  - An unintended pregnancy
  - Adverse outcomes of unintended pregnancy
- Assess Patient's:
  - Understanding of risk
  - Readiness to make needed behavior changes
- Assist in Preventing Unintended Pregnancy
  - Discuss contraception methods
  - Offer prescriptions
  - Encourage latex condom use for STI prevention
  - Refer to PCP, health department, Plan First!, family planning clinic or hotline
- Arrange for Follow-Up

Suggested Clinical Process:

- Medical Assistant/Nurse gives fact sheets to patient ≥18 (reproductive age) to read while waiting to see the physician. Staff advises patient to ask doctor about the fact sheets.
- Or, fact sheets can be handed to the patient when s/he checks in.
- Provider discusses with patient and notes in chart.

How the Guideline Can Help:

User-Friendly Patient Information



Yes! I am planning to have a baby.

Are there other things besides my health I should think about?

- Do you have the support of your partner, family and th
- Does your health plan pay for programs to help you sto the number on your ID card.
- Are there other kinds of help or support you can get?
- On average it costs about $260,700 to raise a child from

For more information contact:

- March of Dimes www.marchofdimes.com 248-359-155
- CDC www.cdc.gov/LifeStages/ click on *Pregnancy*
- American College of Obstetricians and Gynecologists http://www.acog.org/publications/patient_education/bp056.cf
- Your local health department www.michigan.gov/mdch *health department map*

n Cancer Society www.cancer.org click on *Guic*
g

n Lung Association www.lungusa.org click on *F*
g

I am pregnant or plan to become pregnant soon.
What should my doctor and I talk about?

- Health problems you have such as (sugar) diabetes, high blood pressure, asthma or infections.
- Any medicines you are taking including home remedies, herbs and supplements.

I want to decide my own future.
I can choose to wait until I'm ready to have a baby.

What do I need to know about birth control?

There are many kinds of birth control. You and your health care provider can choose the one that fits how you live.

Talk to your doctor about:

- How safe is it?
- How well does it work?
- How easy is it to use?

How do I plan to wait until I'm ready to get pregnant?
You can ask your health care provider about your birth control choices. No matter what type of birth control you choose, regular visits with your doctor are important. Make sure you understand how to use your birth control. Ask if it is still the best birth control choice for you.

What if I am not sure my birth control worked, or I forgot to use my birth control?
Emergency contraception can be taken within five days to prevent pregnancy. It is meant as backup birth control only. It is not as effective as the correct and consistent use of birth control. Ask your doctor or pharmacist.

What about cost?
If you are worried about how to pay for your birth control, tell your doctor cost is a concern for you. If you have a health plan, call the number on your card.
On average it costs about $ 260,700 to raise a child from birth to age 17.

Will my birth control keep me from getting a sexually transmitted disease (STD)?
NO. However if you are sexually active, using condoms **and** other birth control methods **together** will greatly reduce your risk of pregnancy and STDs, including HIV/AIDS.

Not having sex is the only guarantee against pregnancy and STDs, including HIV/AIDS. The only way to be sure you won't get pregnant is not to have sex. Using birth control the right way and every time you

Patient Fact Sheets

- Health-literate
- Interactive
- "News to Use" – info and referral
- "Male perspective" under development
- Free, download at Michigan Surgeon General web page: http://www.michigan.gov/mdch/0,1607,7-132--65525--,00.html

More Information

Plan First!

- Will expand subsidized family planning services to about 200,000 more women in Michigan
- For women who do not have insurance coverage for family planning services, or do not qualify for Medicaid, Plan First! may help pay for out-of-pocket costs related to reproductive health care.
- Covers office visits for family planning related services, lab tests, prescriptions for birth control, contraceptive supplies and devices, treatment of sexually transmitted diseases, some sterilizations for women 21 and older. Does not cover abortions or treatment of infertility.
- For women ages 19-44 years; U.S. citizens or qualified immigrants; must be Michigan residents
- Family income limits - up to 185% of Federal Poverty Level guidelines
- Have a Social Security number or have applied for one
- Are not receiving Medicaid
- Are not pregnant

1-800-642-3195 www.michigan.gov/mdch

Or, go to local health department or MDHS office

More Information for Patients

Preconception Health

- March of Dimes www.marchofdimes.com
  248-359-1550
- CDC www.cdc.gov/LifeStages/
  Click on *Pregnancy*
- Local health department www.michigan.gov/mdch
  Click on *local health dept. map*
- American College of Obstetricians and Gynecologists
  http://www.acog.org/publications/patient_education/bp056.cfm
- American Cancer Society www.cancer.org
  Click on *Guide to Quit Smoking*
- American Lung Association www.lungusa.org
  Click on *Freedom from Smoking*
- MDCH QUITLINE
  800-480-7848
- CDC www.fruitsandveggiesmatter.gov
- Michigan Steps Up www.michiganstepsup.org
- USDA www.fns.usda.gov/wic/

Delay of Pregnancy

- Michigan Medicaid
  www.michigan.gov/mdch
  Click on *health care coverage*
- Plan First!
  800-642-3195
- Your DHS office
  www.michigan.gov/mdch
  Click on *county offices*
- Local health department
  www.michigan.gov/mdch
  Click on *local health dept. map*
- Local Planned Parenthood
  www.plannedparenthood.org
  800-230-PLAN

Background – Organizations & People

Get Involved!

Clinical Guideline for Preventing Unintended Pregnancy in Adults

Governor's Blueprint for Preventing Unintended Pregnancies

First 4 Initiatives

1. ***Plan First!*** Michigan requested and received a waiver from the federal government to allow expanded access to family planning through Medicaid, for women earning up to 185% of the poverty level. This expansion is the Plan First! Program. Since Plan First! was introduced in July 2006, more than 35,000 women have signed up for it, with an estimated savings to the state of approximately $27 million per year.

2. ***Talk Early & Talk Often*** helps parents of middle school children develop the necessary skills to talk to their children about abstinence and sexuality. Since it began in October 2005, more than 70 workshops have been held throughout Michigan in public and parochial schools, medical centers, worship centers, health departments, and libraries.

Governor's Blueprint for Preventing Unintended Pregnancies

First 4 Initiatives (cont'd....)

3. ***Contraceptive Equity*** The Governor has called upon the legislature to require that health plans that cover prescription drugs also cover birth control. Also, the Michigan Civil Rights Commission issued a Declaratory Ruling stating that Michigan employers violate Elliott-Larsen Civil Rights Act if the employer excludes contraceptive coverage in an employer-provided comprehensive health plan that provides prescription drug coverage.

4. ***New Clinical Guideline*** Health care providers are being challenged and supported with user-friendly resources to engage their patients in conversation on this crucial issue, by including discussions about family planning with all men and women of childbearing age, to ask them about their intentions regarding pregnancy and to provide information on family planning. A statewide advisory group of providers built a new evidence-based Clinical Guideline, approved through the Michigan Quality Improvement Consortium, and a toolkit for physicians and other providers to use in counseling their patients.

Michigan Quality Improvement Consortium Mission

"The Michigan Quality Improvement Consortium will establish and implement a core set of clinical practice guidelines and performance measures. The interventions designed and implemented by each plan to improve consistent delivery of services will be at the discretion of individual plans, but guidelines, performance goals, measurement methodology, and performance reporting will be standardized."

http://www.mqic.org

MQIC Participating Organizations

- Blue Cross Blue Shield of Michigan
- Blue Care Network
- Great Lakes Health Plan
- Health Alliance Plan
- HealthPlus of Michigan
- Health Plan of Michigan
- Midwest Health Plan
- Michigan Association of Health Plans
- Michigan Department of Community Health
- Michigan Osteopathic Association
- Michigan State Medical Society
- Molina Health Care of Michigan
- Michigan Peer Review Organization
- OmniCare, A Coventry Health Care Plan
- Physicians Health Plan of Mid-Michigan
- Physicians Health Plan of South Michigan
- Priority Health
- Total Health Care, Inc.
- University of Michigan Health System

http://www.mqic.org

Provider Task Force Composition

- Physicians (OB/GYN, Family Practice, Internal Medicine, Emergency Medicine)
- Nurses/nurse practitioners/nurse midwife
- Community-based/Medicaid and Title X providers
- MDCH, MDHS, local public health
- Michigan Primary Care Consortium, Michigan Quality Improvement Consortium, Michigan Association of Health Plans; ACOG
- Health plans and health systems (medical directors, quality management, IT, provider education)
- Universities/medical schools
- School-based health care
- Psychology/social workers
- Those working with cultural minorities and underserved

Provider Task Force Members

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Office of the Governor

Get Involved!

- To learn more about the new Adult Clinical Guideline for Preventing Unintended Pregnancies, or
- To host a provider presentation, publish a newsletter article, or otherwise communicate the Guideline to relevant audiences, contact:

Office of the Surgeon General
Michigan Department of Community Health
surgeongeneral@michigan.gov
(517) 335-8011

This presentation can be accessed at
http://www.michigan.gov/mdch/0,1607,7-132--65525--,00.html